SERFF Tracking Number:	*HUMA-126866656*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47117*
Company Tracking Number:	*AR-10-005*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR App Maint - HIC Med*		
Project Name/Number:	*Apps Update/Clarity-PROOO24058*		

Filing at a Glance

Company: Humana Insurance Company

Product Name: AR App Maint - HIC Med	SERFF Tr Num: HUMA-126866656	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 47117
Sub-TOI: H16G.001A Any Size Group - PPO	Co Tr Num: AR-10-005	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Wendy Jeffries	Disposition Date: 11/12/2010
	Date Submitted: 10/22/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Apps Update	Status of Filing in Domicile: Not Filed
Project Number: Clarity-PROOO24058	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: na
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 11/12/2010	Explanation for Other Group Market Type:
	State Status Changed: 11/12/2010
Deemer Date:	Created By: Wendy Jeffries
Submitted By: Wendy Jeffries	Corresponding Filing Tracking Number:
PPACA: Not PPACA-Related	

Filing Description:

This is a new filing; the attached forms do not replace or supersede any like forms previously filed. These forms are for use in the group market. These forms are being filed for general use with all approved policy series and may be offered in a printed, online, or digitized audio recorded format.

This application will be used to support our currently marketed products in your state. The changes in the application reflect cosmetic changes in format, design and language. These changes are intended to create a more consumer friendly application form for our future applicants to assist them in understanding the application process.
Included with this submission are the following documents:

SERFF Tracking Number:	*HUMA-126866656*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47117*
Company Tracking Number:	*AR-10-005*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR App Maint - HIC Med*		
Project Name/Number:	*Apps Update/Clarity-PROOO24058*		

·Certificate of Readability; and
·Filing Fee of $500 ($50 per form).

To the best of our knowledge, we believe the attached forms satisfy the minimum requirements of applicable Arkansas statutes and regulations.

If you have any questions regarding this filing, please contact me by phone at (800) 664-4140, extension 1783 or by e-mail at wjeffries@humana.com.

Company and Contact

Filing Contact Information

Wendy Jeffries, Regional Contract Analyst
321 W. Main Street
6th Floor, East Tower
Louisville, KY 40202

wjeffries@humana.ocm
502-580-1783 [Phone]

Filing Company Information

Humana Insurance Company
1100 Employers Boulevard
Green Bay, WI 54344
(800) 558-4444 ext. [Phone]

CoCode: 73288
Group Code: 119
Group Name:
FEIN Number: 39-1263473

State of Domicile: Wisconsin
Company Type: Life & Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$500.00
Retaliatory?	No
Fee Explanation:	10 forms at $50.00 each equals $500.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	$500.00	10/22/2010	41066805

SERFF Tracking Number:	*HUMA-126866656*	*State:*	*Arkansas*
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Project Name/Number:	*Apps Update/Clarity-PROOO24058*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/12/2010	11/12/2010

SERFF Tracking Number:	*HUMA-126866656*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47117*
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Project Name/Number:	*Apps Update/Clarity-PROOO24058*		

Disposition

Disposition Date: 11/12/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HUMA-126866656*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47117*
Company Tracking Number:	*AR-10-005*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR App Maint - HIC Med*		
Project Name/Number:	*Apps Update/Clarity-PROOO24058*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	No
Supporting Document	Application	Approved-Closed	No
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	No
Supporting Document	Statement of Variability	Approved-Closed	No
Form	100+ Employer Group Application	Approved-Closed	No
Form	2-99 Employer Group Application	Approved-Closed	No
Form	Cobra/State Continuation Additional Information	Approved-Closed	No
Form	Underwriting Requirements	Approved-Closed	No
Form	Health Questionaire Additional Page	Approved-Closed	No
Form	Large Group Cobra Additional Information	Approved-Closed	No
Form	Disabled Dependents over the age of 19	Approved-Closed	No
Form	Humana Employee Enrollment Application 2-99 Employees Specialty Benefits	Approved-Closed	No
Form	Humana Evidence of Health Status - Employee Enrollment Application	Approved-Closed	No
Form	Additional Details to Medical Questions	Approved-Closed	No

SERFF Tracking Number:	*HUMA-126866656*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47117*
Company Tracking Number:	*AR-10-005*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR App Maint - HIC Med*		
Project Name/Number:	*Apps Update/Clarity-PROOO24058*		

Form Schedule

Lead Form Number: AR-71012-EA-LG 4/2010

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/12/2010	AR-71012-EA-LG 4/2010	Application/ Enrollment Form	100+ Employer Group Application	Initial			HighlightedAR-71012-EA-LG-0410.pdf
Approved-Closed 11/12/2010	AR-71012-EA-SB 4/2010	Application/ Enrollment Form	2-99 Employer Group Application	Initial			HighlightedAR-71012-EA-SB-0410.pdf
Approved-Closed 11/12/2010	AR-71055 4/2010	Application/ Enrollment Form	Cobra/State Continuation Additional Information	Initial			HighlightedAR-71055-0410.pdf
Approved-Closed 11/12/2010	AR-71056 4/2010	Application/ Enrollment Form	Underwriting Requirements	Initial			HighlightedAR-71056-0410.pdf
Approved-Closed 11/12/2010	GN-71057 4/2010	Application/ Enrollment Form	Health Questionaire Additional Page	Initial			GN-71057-0410.pdf
Approved-Closed 11/12/2010	GN-71059 4/2010	Application/ Enrollment Form	Large Group Cobra Additional Information	Initial			GN-71059-0410.pdf
Approved-Closed 11/12/2010	GN-71063 4/2010	Application/ Enrollment Form	Disabled Dependents over the age of 19	Initial			GN-71063-0410.pdf
Approved-Closed 11/12/2010	AR-72000 4/2010	Application/ Enrollment Form	Humana Employee Enrollment Application 2-99 Employees Specialty Benefits	Initial			HighlightedAR-72000-SB-0410.pdf
Approved-Closed 11/12/2010	AR-72000-HS 4/2010	Application/ Enrollment Form	Humana Evidence of Health Status - Employee Enrollment Application	Initial			HighlightedAR-72000-HS-0410.pdf

SERFF Tracking Number:	*HUMA-126866656*	*State:*	*Arkansas*
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Product Name:	*AR App Maint - HIC Med*		
Project Name/Number:	*Apps Update/Clarity-PROOO24058*		

Approved-Closed 11/12/2010	GN-72000-MH 4/2010	Application/ Enrollment Form	Additional Details to Medical Questions	Initial		GN-72000-MH-0410.pdf

[100+] Employer Group Application - [Arkansas]

HUMANA
Guidance when you need it most

FOR GROUP COVERAGE ([100+] ELIGIBLE EMPLOYEES)

Humana.com or HumanaSpecialtyBenefits.com

[[Medical] [and] [Life] plans [insured] [or] [administered] by [Humana Insurance Company].] [[Dental] plans [insured] [or] [administered] by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Dental HMO] plans offered by [American Dental Providers of Arkansas, Inc.]] [[Vision] plans [insured] [or] [administered] by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability], [Life] [and] [Workplace Voluntary] plans insured by [Kanawha Insurance Company].]

[1-9]. EMPLOYER COMPANY INFORMATION: Please type or print clearly in black ink

Internal use only Group number:

Full legal business name				Requested effective date _ _ / _ _ / _ _ _ _
Corporate/Situs location street address (P.O. Box not allowed)	City	State	ZIP code	County
Billing address (N/A if same as street address)	City	State	ZIP code	County

Type of business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other (explain) _____	Date company established	Federal Tax ID
Nature of business/SIC code	Business phone number ( )	Business fax number ( )

Do you have more than one location? ☐ No ☐ Yes

Benefit Administrator/Management contact name:

Phone number ( )	Fax number ( )	E-mail

Management contact: Mother's maiden name _____
(this will be used to gain access to the Employer Self-Service Center on www.Humana.com)

Billing contact name:

Phone number ( )	Fax number ( )	E-mail

[Are separate divisions/classes required for billing or reporting? ☐ No ☐ Yes] [If yes, please explain. If additional space is needed, please attach an additional page. Each additional page must be signed and dated.]

Also complete this section if you are selecting Workplace Voluntary Benefits
Is this group a government entity or a church? ☐ No ☐ Yes
Due date Effective date of policy and due date of first premium will be (month, day, year) _ _ / _ _ / _ _ _ _

Group Term Life only
Eligibility for Experience Refunds applied for ☐ No ☐ Yes

[1-9]. ELIGIBILITY REQUIREMENTS

Number of employees on payroll _____. An employee who is eligible to apply for insurance is one who is actively at work on a full-time basis working at least the number of hours per week as indicated in the table below.

	All	[Medical]	[Dental]	[Life]	[Vision]	[STD]	[LTD]	[Critical Illness]	[Workplace Voluntary]
A. [Number of hours worked per week to be eligible (select between [0-20] and [0-40] hours)]									
B. [Number of employees in a probationary waiting period (do not include in the eligible count below in C)]									
C. [Total number of eligible employees]									
[Number of employees:									
• [waiving with other qualifying coverage]									
• [waiving without other qualifying coverage]]									
[Number of employees to be enrolled]									

[1-9]. ELIGIBILITY REQUIREMENTS (continued)

[Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (specify) _____
(if you prefer months, please select "Other" and specify the number of months)]

[New/Rehire employee effective provision: (On all plans, the employee termination date coincides with the effective date provision.)
☐ First of month following probationary waiting period ☐ Immediately following probationary waiting period]

[Do you want to exclude a class of employees? ☐ No ☐ Yes]
[If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)
☐ union ☐ non-union ☐ hourly ☐ salary ☐ management ☐ non-management ☐ Other:_____]

[Has this group been insured by Humana within the last three years? ☐ No ☐ Yes]
[If yes, please provide prior group number and termination date:]

[Is this a Collectively Bargained Plan? ☐ No ☐ Yes] [Name of Plan_____
Plan number _____ (Assigned by Employer for use in filing IRS form 5500)]

[Additional classes and corresponding number of employees to be included:
☐ Seasonal ☐ Part-time ☐ Other - explain (e.g. contract employee, independent contractor, directors) _____]

[Will the group be offering Domestic Partner Coverage? ☐ No ☐ Yes]

[Retiree information
[For groups 26+, are you offering coverage to retirees? ☐ No ☐ Yes] [If yes, required age _____ Minimum years of service _____]

	All	Medical	Dental	Vision	Life (if applicable)
Number of current retirees to be covered]					

[Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a federal or state combined tax return? ☐ No ☐ Yes] [If yes, enter information below:

Company name	Total employees
	]

As of the date of this application, list any employees currently disabled and not actively at work: (attach additional signed and dated pages if necessary)

Group Term Life, Short Term Disability, Long Term Disability and Critical Illness only

Effective dates for changes in amounts of coverage

[Increases/decreases due to change in class: ☐ effective first day of month following date change ☐ Other _____]

[Increases/decreases requested by employee: ☐ effective first day of month following date requested ☐ Other _____]

[Increases (with Evidence of Insurability) requested by employee: ☐ effective first day of month following approval date ☐ Other _____]

[Decreases due to age: ☐ effective first day of month following age change ☐ Other _____]

[Evidence of Insurability required if amount of Basic plus Voluntary Life Insurance applied for exceeds amounts below:

	Class [1-2]	Class [1-2]
[Employee life]	$	$
[Spouse life]	$	$
[Employee LTD]	$	$
[Basic group critical illness]	$	$
[Buy-up group critical illness]	$	$]

[☐ **Special requests:** Check box and attached signed additional sheet or letter if custom dating, face amounts, etc. are desired.]

[1-9]. COBRA/STATE CONTINUATION

[Is your group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes]				
[Number of existing COBRA participants	[Medical:]	[Dental:]	[Vision:]	[Supplemental Health:]]
[How many in COBRA election period	[Medical:]	[Dental:]	[Vision:]	[Supplemental Health:]]
[Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes] [If yes, enter information below. Attach additional signed and dated sheets (reorder AR-52247) if necessary.				

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc.)	Qualifying event date	COBRA/State Continuation	
			Start date	End date
				]

[1-9]. EMPLOYER CONTRIBUTION(S)

Coverage	[Medical]	[Dental]	[Life]	[Vision]	[STD]	[LTD]	[Workplace Voluntary]	[Spending Account*]
Employer's contribution for: [Employee	%	%	%	%	%	%	%	$]
[Employee/spouse	%	%	%	%	N/A	N/A	%	$]
[Employee/child	%	%	%	%	N/A	N/A	%	$]
[Family	%	%	%	%	N/A	N/A	%	$]

[(Medical only) Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes]
[If yes, indicate amount funded $_____]

[*For medical plans, Humana reserves the right to re-evaluate rates and require new premium prior to underwriting approval or issuing coverage with employer contributions greater than [0-100]% of a plan's deductible to an employee's Spending Account.]

Group Term Life only

Coverage requested	Employee contribution %	Benefit amount (Class and amount)
[[Employee] [Basic Term Life]		
[Supplemental Term Life]		
[Basic AD&D]		
[Supplemental AD&D]]		
[[Spouse] [Basic Term Life]		
[Supplemental Term Life]		
[Basic AD&D]		
[Supplemental AD&D]]		
[[Child(ren)] [Basic Term Life]		
[Supplemental Term Life]		
[Basic AD&D]		
[Supplemental AD&D]]		

Optional benefits	Benefit amount
[Waiver of Premium]	
[Accelerated benefit for terminal illness]	
[AD&D benefits:] [☐ Paralysis]	
[☐ Transportation]	
[☐ Seatbelt and airbag]	
[☐ Coma]	
[☐ Common carrier]	
[☐ Occupational assault]	
[Special education/Training:] [☐ Insured only] [☐ Spouse only] [☐ Insured and spouse]	
[Licensed day care (Child/Children only)]	
[Portability ☐ No ☐ Yes]	

[1-9]. PRIOR/CURRENT CARRIER INFORMATION

	[Medical]	[Dental]	[Life]	[STD]	[LTD]
[Is this group transferring from another group carrier?]	[☐ No ☐ Yes]	[☐ No ☐ Yes]	[☐ No ☐ Yes]	[☐ No ☐ Yes]	[☐ No ☐ Yes]
[If yes, provide carrier name]					
[Did prior dental coverage include orthodontia? If yes, submit most recent carrier billing with effective and termination dates.]	[N/A]	[☐ No ☐ Yes]	[N/A]	[N/A]	[N/A]
[Proposed termination date]					

[(Medical only) Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes]
[If yes, indicate amount funded $_____]

For Workplace Voluntary Benefits

Existing coverage available to employees

[Disability income carrier _____ ☐ Individual ☐ Group Coverage termination date_____]

[CI/Cancer carrier _____ ☐ Individual ☐ Group Coverage termination date_____]

[1-9]. PRODUCT SELECTION -

To complete this section, please refer to the Underwriting Requirements (reorder AR-52347) and your proposal. Also review the Regulatory Pre-enrollment Disclosure Guide with your Broker.

[Workers' Compensation (applicable for Medical plans all group sizes)
[Do you wish to have 24-hour coverage for employees not covered by Workers' Compensation? ☐ No ☐ Yes
[If yes, name(s):]]

[a-z]. MEDICAL PLANS

[Is this a SmartSuite selection? ☐ No ☐ Yes]

Product specification:	Product specification:
Product specification:	Product specification:
Product specification:	Product specification:

☐ Health Care Flexible Spending Account (FSA) ☐ Dependent Care Flexible Spending Account (FSD) ☐ Health Savings Account
☐ Personal Care Account offered with Product specification:

[Are there any disabled dependents over the age of 19 to be covered in this group? ☐ No ☐ Yes]
[If yes, please provide on a separate sheet of paper (reorder GN-52422): name of employee, dependent name, statement of disability/diagnosis from attending physician, dependency statement from employee and the current group carrier insuring the dependent.]

[To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period: (check all that apply)

- [confined at home, in a hospital, or a treatment facility ☐ No ☐ Yes]
- [who incurred more than $[1-25,000] of medical expenses in the last [1-12] months ☐ No ☐ Yes]
- [who has been advised within the last [1-90] days to have surgery or be hospitalized ☐ No ☐ Yes]
- [who is eligible for and/or covered by Medicare related to a disability or End-Stage Renal Disease ☐ No ☐ Yes]]

[For any checked option, please complete the information below. Attach additional signed and dated sheets (reorder GN-52338) if necessary.

Member Status*	Age	Medical Condition/Diagnosis	Date(s) of Treatment	Medication Name/Dosage	Past/Current/Future Treatment
					]

* Member Status: E=Employee D=Dependent C=COBRA R=Retiree Class

[a-z]. DENTAL PLANS (all group sizes)

	Plan [1-2]	Plan [1-2]
Plan name (as shown on your proposal)		
Funding type	☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Coinsurance	In % / / Out % / /	In % / / Out % / /
Deductible	In $ Out $	In $ Out $
Annual Maximum	$	$
Preventive Services deductible options	☐ Apply deductible ☐ Waive deductible	☐ Apply deductible ☐ Waive deductible
Periodontic/Endondontic options	☐ Basic ☐ Major	☐ Basic ☐ Major
Composite Fillings for Molars	☐ No ☐ Yes	☐ No ☐ Yes
Implant Coverage	☐ No ☐ Yes	☐ No ☐ Yes
Orthodontia options	☐ Child only: Lifetime Ortho Max $_____ ☐ Adult & Child: Lifetime Ortho Max $ _____	☐ Child only: Lifetime Ortho Max $_____ ☐ Adult & Child: Lifetime Ortho Max $ _____
Out of network reimbursement options	☐ Max allowable fee ☐ In-network fee schedule	☐ Max allowable fee ☐ In-network fee schedule
Open Enrollment	☐ No ☐ Yes	

[a-z]. LIFE (all group sizes) - Please refer to your proposal

Basic Employee Life and AD&D (AD&D only applicable to certain plans)

☐ Flat amount—indicate level: $_____ Increment (if applicable) $_____

☐ Salary plan—options are [1x to 6+x] salary, rounded to the next highest $[1-1,000]. Indicate salary level: _____ x salary

☐ Class schedule—no more than [1-2.5] times between the classes and 10 times between the lowest and highest class (complete table below).

Class	Description	Benefit Amount / Salary Factor
I		
II		
III		
IV		

Basic Dependent Life ☐ No ☐ Yes If yes, indicate volume amount $_____]

Voluntary Life

Voluntary Employee Life ☐ No ☐ Yes If yes, do you want to select AD&D? ☐ No ☐ Yes

Voluntary Dependent Life (Available only when enrolled in Voluntary Life) ☐ No ☐ Yes

Portability of coverage (Applicable to Voluntary Life only) ☐ No ☐ Yes]

[a-z]. GROUP CRITICAL ILLNESS (all group sizes)

[Plan design] [☐ Benefits provided in conjunction with a HSA plan] [☐ Benefits offered in conjunction with an IRS-qualified pre-tax plan]

[Coverage choices] [[☐ Vascular] [Heart attack _____% of face amount] [Heart transplant _____% of face amount]
[Stroke _____% of face amount] [Coronary artery bypass surgery _____% of face amount]]
[[☐ Cancer] [Invasive cancer or malignant melanoma _____% of face amount]
[Carcinoma in situ _____% of face amount]]
[[☐ Other critical illness 50 or 100% of face amount] [☐ Major organ transplant] [☐ End stage renal failure]
[☐ Loss of vision, speech or hearing] [☐ Coma]
[☐ Severe burns] [☐ Permanent paralyais due to accident]]
[☐ Occupational HIV benefit]

[Optional benefits - Employer selectable] [☐ None] [☐ Benefit Recurrence _____% of face amount]
[☐ Takeover benefits] [☐ Health screening benefit: ☐ $50 ☐ $100 ☐ $150]
[☐ Loss of work: _____ maximum number of months]

[Face amount (employee/member)] [☐ Class I Basic: $_____] [☐ Class I Buy-up/Optional: $_____]
[☐ Class II Basic: $_____] [☐ Class II Buy-up/Optional: $_____]

[Family options] [☐ Spouse Basic: $_____ or _____% of employee/member amount] [☐ Buy-up/Optional: $_____ or _____% of employee/member amount]
[☐ Child(ren) Basic: $_____ or _____% of employee/member amount] [☐ Buy-up/Optional: $_____ or _____% of employee/member amount]

[Maximum benefit amount] [☐ Basic: $_____] [☐ Buy-up/Optional: $_____]

[Waiver of premium] [☐ Included]

[a-z]. VISION PLANS (all group sizes)

	Plan 1	[Plan 2]
Plan name (as shown on your proposal)		

[Vision Options [(For groups 100+ with a custom vision plan, please list the in-network benefit options below.)]

[Funding type]	[☐ Employer sponsored] [☐ Voluntary]	[☐ Employer sponsored] [☐ Voluntary]
[Exam / material copayment]	/	/
[Frame allowance]		
[Contact lens allowance]		
[Frequency]]		

[a-z]. SHORT TERM DISABILITY (group sizes [2+]). Attach additional signed and dated sheets (reorder GN-52336) if necessary.

	Class [1-2]	Class [1-2]
[Name of Class]		
[Funding type]	[☐ Contributory] [☐ Non-contributory] [☐ Voluntary]	[☐ Contributory] [☐ Non-contributory] [☐ Voluntary]
[Benefit schedule (select one)]	[☐ [0-100]%] [☐ [0-100]%] [☐ [0-100]%] [☐ Other] [☐ Flat amount $_____]	[☐ [0-100]%] [☐ [0-100]%] [☐ [0-100]%] [☐ Other] [☐ Flat amount $_____]
[Weekly benefit maximum]	[$]	[$]
[Duration weeks]	[Weeks:] [☐ 13] [☐ 26] [☐ 52] [☐ Other _____]	[Weeks:] [☐ 13] [☐ 26] [☐ 52] [☐ Other _____]
[Elimination period]	[☐ 1/8] [☐ 8/8] [☐ 15/15] [☐ 30/30] [☐ Other __]	[☐ 1/8] [☐ 8/8] [☐ 15/15] [☐ 30/30] [☐ Other __]
[Pre-existing limitation]	[☐ None] [☐ 3/3/12]	[☐ None] [☐ 3/3/12]
[Actively at work]	[_____hrs per] [☐ week] [☐ month] [☐ Other_____]	[_____hrs per] [☐ week] [☐ month] [☐ Other_____]
[Waiting period: Current employees]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]
[Waiting period: Rehired employees]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]
[Rate guarantee]	[Year:] [☐ 2] [☐ Other_____]	[Year:] [☐ 2] [☐ Other_____]

[a-z]. LONG TERM DISABILITY (for group sizes 2+) Attach additional signed and dated sheets (reorder GN-52336) if necessary.

	Class [1-2]	Class [1-2]
[Name of Class]		
[Funding type]	[☐ Contributory] [☐ Non-contributory] [☐ Voluntary]	[☐ Contributory] [☐ Non-contributory] [☐ Voluntary]
[Benefit schedule (select one)]	[☐ [0-100]%] [☐ [0-100]%] [☐ [0-100]%] [☐ Other] [☐ Flat amount $_____]	[☐ [0-100]%] [☐ [0-100]%] [☐ [0-100]%] [☐ Other] [☐ Flat amount $_____]
[Monthly benefit minimum]	[☐ $100] [☐ 10]% of monthly salary	[☐ $100] [☐ 10]% of monthly salary
[Monthly benefit maximum]	[$]	[$]
[Duration]	[☐ 2 Year] [☐ 5 Year] [☐ SSNRA] [☐ Other_____]	[☐ 2 Year] [☐ 5 Year] [☐ SSNRA] [☐ Other_____]
[Elimination period]	[Days:] [☐ 30] [☐ 60] [☐ 90] [☐ 120] [☐ Other ___]	[Days:] [☐ 30] [☐ 60] [☐ 90] [☐ 120] [☐ Other ___]
[Definition of disability]	[Years own occupation:] [☐ 2] [☐ 3] [☐ to age 65] [☐ Other_____]	[Years own occupation:] [☐ 2] [☐ 3] [☐ to age 65] [☐ Other_____]
[Pre-existing limitation]	[☐ 3/3/12] [☐ 3/6/12] [☐ 6/6/12] [☐ 6/6/24] [☐ 12/12/24] [☐ Other_____]	[☐ 3/3/12] [☐ 3/6/12] [☐ 6/6/12] [☐ 6/6/24] [☐ 12/12/24] [☐ Other_____]
[Mental health and substance abuse limitation]	[☐ 24 months] [☐ Other_____]	[☐ 24 months] [☐ Other_____]
[Survivor benefits]	[☐ 3 x] [☐ 6 x] lump sum	[☐ 3 x] [☐ 6 x] lump sum
[Waiting period: Current employees]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]
[Waiting period: Rehired employees]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]
[Rate guarantee]	[Year:] [☐ 2] [☐ 3] [☐ Other_____]	[Year:] [☐ 2] [☐ 3] [☐ Other_____]

[a-z]. LONG TERM DISABILITY (continued)

Additional benefits (for LTD only): Please refer to your proposal for additional benefits availability with plan selected. Attach additional signed and dated sheets (reorder GN-52336) if necessary.

	Class [1-2]	Class [1-2]
[Cost of Living Adjustment ([0-100]%)]	[☐ No ☐ Yes] [If yes, select years: ☐ 5 ☐ 10]	[☐ No ☐ Yes] [If yes, select years: ☐ 5 ☐ 10]
[Activities of Daily Living]	[☐ No ☐ Yes] [If yes, select %: [☐ [0-100]] [☐ [0-100]] [☐ [0-100]] [☐ [0-100]]]	[☐ No ☐ Yes] [If yes, select %: [☐ [0-100]] [☐ [0-100]] [☐ [0-100]] [☐ [0-100]]]
[Infectious & Contagious Disease]	[☐ No ☐ Yes]	[☐ No ☐ Yes]
[Accidental Dismemberment and Loss of Sight]	[☐ No ☐ Yes]	[☐ No ☐ Yes]
[Business Income Protection]	[☐ No ☐ Yes]	[☐ No ☐ Yes]
[Pension Contribution]	[☐ No ☐ Yes]	[☐ No ☐ Yes]
[Extended Earnings]	[☐ No ☐ Yes]	[☐ No ☐ Yes]
[Medical Premium Supplemental]	[☐ No ☐ Yes]	[☐ No ☐ Yes]

[a-z]. WORKPLACE VOLUNTARY (all group sizes)

[DISABILITY] [☐ No ☐ Yes] **[Plan design]** [☐ Benefits are provided in conjunction with a HSA plan] [☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]

[Benefit period (select all that apply)] [☐ 3 Months] [☐ 6 Months] [☐ 1 Year] [☐ 2 Years] [☐ 3 Years]

[Elimination period (select all that apply)] [☐ 0/7] [☐ 7/7] [☐ 0/14] [☐ 14/14] [☐ 30/30] [☐ 60/60] [☐ 90/90] [☐ 180/180] [☐ 365/365]

[Optional benefits - Employer selectable] [☐ Loss of Work] [☐ 24 Hour Coverage Rider] [☐ Takeover benefit] [☐ Mental, Nervous, Alcohol and Drug Abuse Rider] [☐ Portability] [☐ Sickness Elimination Period Waiver (Available only if 7 or 14 day Elimination Period is selected for Sickness)]

[Optional benefits - Employee selectable] [☐ COBRA benefit] [☐ Physical Therapy benefit] [☐ ICU/CCU]

[ACCIDENT INSURANCE] [☐ No ☐ Yes] **[Base plan]** [☐ Level 1] [☐ Level 2] [☐ Level 3] [☐ Level 4]

[Optional Benefits] [☐ Hospital Intensive Care Unit benefit] [☐ $150] [☐ $300] [☐ $450] [☐ $600] [☐ Fracture and Dislocation benefit] [☐ $750] [☐ $1,500] [☐ Accident Total Disability benefit (Elimination period)] [☐ 1 Day] [☐ 7 Days] [☐ 14 Days] [☐ 30 Days] [☐ On-the-Job Coverage benefit]

[CRITICAL ILLNESS] [☐ No ☐ Yes] **[Plan design]** [☐ Benefits are provided in conjunction with a HSA plan] [☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]

[Coverage choices] [☐ Vascular] [☐ Cancer] [☐ Other critical illnesses %]

[Optional benefits - Employer selectable] [☐ Benefit Recurrence] [☐ Loss of Work] [☐ Takeover benefit]

[Optional benefits - Employee selectable] [☐ Health Screening benefit $_____] [☐ Automatic Benefit Increase]

[CRITICAL LIFE] [☐ No ☐ Yes] **[Plan design]** [☐ 10 Year] [☐ 20 Year]

[Optional benefits - Employer selectable] [☐ Waiver of Premium] [☐ Loss of Work] [☐ Takeover benefit] [☐ Additional Benefit Increase] [☐ Accelerated Living benefit - Critical illness _____%] [☐ Accidental Death and Loss of Sight Dismemberment]

[SUPPLEMENTAL HEALTH] [☐ No☐ Yes] **[Base plan]**	[☐ Plan A]	[☐ Plan B]	[☐ Plan C]	[☐ Plan D]
[Hospital Indemnity] [Hospital First Occurence]	[$[50-6,000]/day] [$[250-4,000]/ day [(days [1-7]),] [$[250-4,000]/day [(days [1-7])]	[$[50-6,000]/day] [$[250-4,000]/ day [(days [1-7]),] [$[250-4,000]/day [(days [1-7])]	[$[50-6,000]/day] [$[250-4,000]/ day [(days [1-7]),] [$[250-4,000]/day [(days [1-7])]	[$[50-6,000]/day] [$[250-4,000]/ day [(days [1-7]),] [$[250-4,000]/day [(days [1-7])]
[Optional benefits - Employer selectable]				
[☐ Emergency Room]	[$[25-6,000]/day (ER),] [$[25-6,000]/ day (urgent care)]	[$[25-6,000]/day (ER),] [$[25-6,000]/ day (urgent care)]	[$[25-6,000]/day (ER),] [$[25-6,000]/ day (urgent care)]	[$[25-6,000]/day (ER),] [$[25-6,000]/ day (urgent care)]
[☐ ICU/CCU/Burn Unit benefit]	[$[50-12,000]/day]	[$[50-12,000]/day]	[$[50-12,000]/day]	[$[50-12,000]/day]
[☐ Surgical Schedule]	[$[500-8,000]]	[$[500-8,000]]	[$[500-8,000]]	[$[500-8,000]]
[☐ Diagnostic, Laboratory and X-ray]	[$[25-200]/test (hospital),] [$[25-200]/test (doctor's office or clinic)]	[$[25-200]/test (hospital),] [$[25-200]/test (doctor's office or clinic)]	[$[25-200]/test (hospital),] [$[25-200]/test (doctor's office or clinic)]	[$[25-200]/test (hospital),] [$[25-200]/test (doctor's office or clinic)]
[☐ Outpatient Office Visit]	[$[25-400]]	[$[25-400]]	[$[25-400]]	[$[25-400]]
[☐ Wellness]	[$[35-600]]	[$[35-600]]	[$[35-600]]	[$[35-600]]

[If multiple plans are selected and plan availability is limited by class, please list what class of employees are eligible for each plan.]

[1-9]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY

The companies listed on this Employer Group Application, severally or collectively as the context may require, are referred to in this application as we, us and our.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

Small employer means a person, firm, corporation, partnership or association actively engaged in business, which employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, unless otherwise provided under the state law. Affiliated or subsidiary companies that are eligible to file a combined tax return are considered one employer.

You agree to make available your records which we determine are relevant to this application and group coverage for inspection by the Trustee, Administrator, us or our representative during your normal business hours.

As claims administrator with authority to make claim determinations as described in Section 503 of ERISA, we make final decisions under the Policy or Certificate with respect to determining eligibility for coverage and paying claims for benefits, including deciding appeals of denied claims. As claims administrator, we shall have full and exclusive discretionary authority to: (1) interpret Policy or Certificate provisions; (2) make decisions regarding eligibility for coverage and benefits; and (3) resolve factual questions relating to coverage and benefits.

You understand and agree that failure to remit and pay premium when due will be considered a default in premium payment, and that coverage will be terminated by us, following a grace period of 31 days from the date of non-payment of premium. We may terminate your coverage according to the termination section of the Policy or Certificate. Except for non-payment of premium or when a group or individual is not or has not been eligible for coverage, you will be provided with a 30 day advance written notice, unless a greater period is expressly specified in the Policy. If coverage is terminated by us for non-payment of premium, you will still owe and we will collect all due premium including premium for the grace period.

You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law, after your insurance has been in effect under the Policy for six consecutive months. Changes to premium rates for short term disability plans may differ if you have agreed to participate in a Rate Guarantee program. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility, underwriting and participation requirements will terminate your coverage under the Policy or Certificate. Other termination provisions are stated in the Policy or Certificate.

Based upon our standard underwriting practice, we may require an employee or dependent to submit Evidence of Health Status. We have the right to use the information provided by you and any applicant (employee or dependent) to determine whether coverage will be provided, to determine eligibility and to establish appropriate premiums. Any health related information that has been provided will not be used to decline medical coverage unless permitted by law.

[1-9]. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

You the employer, understand, agree and represent: You have read this document and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed a proposal and the applicable regulatory information required by your state. Neither you nor the agent/broker/producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. The first month's estimated premium (which may include a monthly administrative fee), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application before action is taken on this application. Unless we are informed differently, we will perform a one-time electronic check conversion of the first month's premium payment from the account and for the amount designated on the binder check. You will collect any employee contribution toward premium. Our acceptance of premium does not guarantee coverage. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. If choosing the HDHP Indexing Plan, deductible and out of pocket amounts are established by IRS guidelines. Adjustments to these amounts by the IRS will be made to the policy, without notice, upon renewal of the group. This document will form part of any contract or coverage issued. Coverage is not in effect unless and until you receive written notification from us. If this application is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.

Dated on: _____ (month, date, year) at _____ (city and state)

By: _____ _____ _____

(Employer printed name) (Employer signature) (Title)

[For Workplace Voluntary Benefits - only necessary for non-employer groups.

By: _____ _____ _____

(Plan sponsor printed name) (Plan sponsor signature) (Title)]

[1-9]. AGENT/PRODUCER INFORMATION

1. Agency of Record (for commissions and correspondence)	2. Agent/Agency of Record (for split commissions)
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent (Producer)	**2. Writing Agent (Producer)**
Name (print or type)	Name (print or type)
Social Security Number/Humana Agent Number	Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)

General Agency (Complete only if agency involved in sale)

General agency information pertains to: ☐ Agency of Record ☐ Writing Agent			
Name (print or type)	Tax ID/Humana Agent Number		
Address	City	State	ZIP code

As the Writing Agent/Producer, I acknowledge that I am responsible to meet with the employer submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent's Signature:_____ Date:_____

[2-99] Employer Group Application - [Arkansas]

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FOR GROUP COVERAGE ([2-99] ELIGIBLE EMPLOYEES)

Humana.com or HumanaSpecialtyBenefits.com

[[Medical] [and] [Life] plans [insured] [or] [administered] by [Humana Insurance Company].] [[Dental] plans [insured] [or] [administered] by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Dental HMO] plans offered by [American Dental Providers of Arkansas, Inc.]] [[Vision] plans [insured] [or] [administered] by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Group Critical Illness], [Short Term Disability], [Long Term Disability], [Life] [and] [Workplace Voluntary] plans insured by [Kanawha Insurance Company].]

[1-9]. EMPLOYER COMPANY INFORMATION: Please type or print clearly in black ink

Internal use only Group number:

Full legal business name				Requested effective date _ _ / _ _ / _ _ _ _
Corporate/Situs location street address (P.O. Box not allowed)	City	State	ZIP code	County
Billing address (N/A if same as street address)	City	State	ZIP code	County
Type of business ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other (explain) _____		Date company established		Federal Tax ID
Nature of business/SIC code	Business phone number ( )		Business fax number ( )	
Do you have more than one location? ☐ No ☐ Yes				
Benefit Administrator/Management contact name:				
Phone number ( )	Fax number ( )		E-mail	
Management contact: Mother's maiden name _____ (this will be used to gain access to the Employer Self-Service Center on www.Humana.com)				
Billing contact name:				
Phone number ( )	Fax number ( )		E-mail	
[Are separate divisions/classes required for billing or reporting? ☐ No ☐ Yes] [If yes, please explain. If additional space is needed, please attach an additional page. Each additional page must be signed and dated.]				

Also complete this section if you are selecting Workplace Voluntary Benefits
Is this group a government entity or a church? ☐ No ☐ Yes
Due date Effective date of policy and due date of first premium will be (month, day, year) _ _ / _ _ / _ _ _ _

[1-9]. ELIGIBILITY REQUIREMENTS

Number of employees on payroll _____. An employee who is eligible to apply for insurance is one who is actively at work on a full-time basis working at least the number of hours per week as indicated in the table below.

	All	[Medical]	[Dental]	[Life]	[Vision]	[STD]	[LTD]	[Critical Illness]	[Workplace Voluntary]
A. [Number of hours worked per week to be eligible (select between [0-20] and [0-40] hours)]									
B. [Number of employees in a probationary waiting period (do not include in the eligible count below in C)]									
C. [Total number of eligible employees]									

[Probationary waiting period for eligible employees: ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (specify) _____
(if you prefer months, please select "Other" and specify the number of months)]

[New/Rehire employee effective provision: (On all plans, the employee termination date coincides with the effective date provision.)
☐ First of month following probationary waiting period ☐ Immediately following probationary waiting period]

[Do you want to exclude a class of employees? ☐ No ☐ Yes]
[If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)
☐ union ☐ non-union ☐ hourly ☐ salary ☐ management ☐ non-management ☐ Other:_____]

[1-9]. ELIGIBILITY REQUIREMENTS (continued)

[Has this group been insured by Humana within the last three years? ☐ No ☐ Yes]
[If yes, please provide prior group number and termination date:]

[Is this a Collectively Bargained Plan? ☐ No ☐ Yes] [Name of Plan_____
Plan number _____ (Assigned by Employer for use in filing IRS form 5500)]

[Retiree information
[For groups 26+, are you offering coverage to retirees? ☐ No ☐ Yes] [If yes, required age _____ Minimum years of service _____]

	All	Medical	Dental	Vision	Life (if applicable)
Number of current retirees to be covered]					

[Does this company have any subsidiaries or affiliates, or are there any other associated entities that are eligible to file a federal or state combined tax return? ☐ No ☐ Yes] [If yes, enter information below:

Company name	Total employees
	]

As of the date of this application, list any employees currently disabled and not actively at work: (attach additional signed and dated pages if necessary)

Group Term Life, Short Term Disability, Long Term Disability and Critical Illness only

Effective dates for changes in amounts of coverage

[Increases/decreases due to change in class: ☐ effective first day of month following date change ☐ Other _____]
[Increases/decreases requested by employee: ☐ effective first day of month following date requested ☐ Other _____]
[Increases (with Evidence of Insurability) requested by employee: ☐ effective first day of month following approval date ☐ Other _____]
[Decreases due to age: ☐ effective first day of month following age change ☐ Other _____]
[Evidence of Insurability required if amount of Basic plus Voluntary Life Insurance applied for exceeds amounts below:

	Class [1-2]	Class [1-2]
[Employee life]	$	$
[Spouse life]	$	$
[Employee LTD]	$	$
[Basic group critical illness]	$	$
[Buy-up group critical illness]	$	$]

[☐ **Special requests:** Check box and attached signed additional sheet or letter if custom dating, face amounts, etc. are desired.]

[1-9]. COBRA/STATE CONTINUATION

[Is your group subject to: COBRA ☐ No ☐ Yes State Continuation ☐ No ☐ Yes]

[Number of existing COBRA participants	[Medical:]	[Dental:]	[Vision:]	[Supplemental Health:]]
[How many in COBRA election period	[Medical:]	[Dental:]	[Vision:]	[Supplemental Health:]]

[Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ☐ No ☐ Yes]
[If yes, enter information below. Attach additional signed and dated sheets (reorder AR-52247) if necessary.

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc.)	Qualifying event date	COBRA/State Continuation	
			Start date	End date
				]

[1-9]. EMPLOYER CONTRIBUTION(S)

Coverage	[Medical]	[Dental]	[Life]	[Vision]	[STD]	[LTD]	[Workplace Voluntary]	[Spending Account*]
Employer's contribution for: [Employee	%	%	%	%	%	%	%	$]
[Employee/spouse	%	%	%	%	N/A	N/A	%	$]
[Employee/child	%	%	%	%	N/A	N/A	%	$]
[Family	%	%	%	%	N/A	N/A	%	$]

[(Medical only) Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes]
[If yes, indicate amount funded $_____]

[*For medical plans, Humana reserves the right to re-evaluate rates and require new premium prior to underwriting approval or issuing coverage with employer contributions greater than [0-100]% of a plan's deductible to an employee's Spending Account.]

Group Term Life only

Coverage requested	Employee contribution %	Benefit amount (Class and amount)
[[Employee] [Basic Term Life]		
[Supplemental Term Life]		
[Basic AD&D]		
[Supplemental AD&D]]		
[[Spouse] [Basic Term Life]		
[Supplemental Term Life]		
[Basic AD&D]		
[Supplemental AD&D]]		
[[Child(ren)] [Basic Term Life]		
[Supplemental Term Life]		
[Basic AD&D]		
[Supplemental AD&D]]		

Optional benefits	Benefit amount
[Waiver of Premium]	
[Accelerated benefit for terminal illness]	
[AD&D benefits:] [☐ Paralysis]	
[☐ Transportation]	
[☐ Seatbelt and airbag]	
[☐ Coma]	
[☐ Common carrier]	
[☐ Occupational assault]	
[Special education/Training:] [☐ Insured only] [☐ Spouse only] [☐ Insured and spouse]	
[Licensed day care (Child/Children only)]	

[1-9]. PRIOR/CURRENT CARRIER INFORMATION

	[Medical]	[Dental]	[Life]	[STD]	[LTD]
[Is this group transferring from another group carrier?]	[☐ No ☐ Yes]	[☐ No ☐ Yes]	[☐ No ☐ Yes]	[☐ No ☐ Yes]	[☐ No ☐ Yes]
[If yes, provide carrier name]					
[Did prior dental coverage include orthodontia? If yes, submit most recent carrier billing with effective and termination dates.]	[N/A]	[☐ No ☐ Yes]	[N/A]	[N/A]	[N/A]
[Proposed termination date]					
[(Medical only) Do you as an employer currently fund any of the plan deductible for the employees? ☐ No ☐ Yes] [If yes, indicate amount funded $_____]					

[1-9]. PRIOR/CURRENT CARRIER INFORMATION (continued)

(For Medical only employees) Group's renewal date:

Current carrier rates	Employee $	Spouse $	Child(ren) $	Family $
Plan design		Office visit copay $	Per confinement copay $	
Coinsurance In %_____ Out %_____		Deductible In %_____ Out%_____	Out of pocket In %_____ Out %_____	
Emergency room copay $		Prescrption drug benefit		
Renewal rates	Employee $	Spouse $	Child(ren) $	Family $

[How many medical carriers have you had in the past five years?]

For Workplace Voluntary Benefits

Existing coverage available to employees

[Disability income carrier _____ ☐ Individual ☐ Group Coverage termination date_____]

[CI/Cancer carrier _____ ☐ Individual ☐ Group Coverage termination date_____]

[1-9]. PRODUCT SELECTION - To complete this section, please refer to the Underwriting Requirements (reorder AR-52347) and your proposal. Also review the Regulatory Pre-enrollment Disclosure Guide with your Broker.

[Workers' Compensation (applicable for Medical plans all group sizes)
[Do you wish to have 24-hour coverage for employees not covered by Workers' Compensation? ☐ No ☐ Yes
[If yes, name(s):]]

[a-z]. MEDICAL PLANS

	Plan [1-3]	**Plan [1-3]**	**Plan [1-3]**
Plan name (as shown in your proposal)			
Office/Specialist copay (if applicable)	$ / $	$ / $	$ / $
Coinsurance	In % / Out %	In % / Out %	In % / Out %
Deductible	In $ / Out $	In $ / Out $	In $ / Out $
Out-of-pocket limit	In $ / Out $	In $ / Out $	In $ / Out $
Prescription Drug/Retail Card (Level 1 / 2 / 3 / 4)	$ /$ /$ / %	$ /$ /$ / %	$ /$ /$ / %
Prescription Drug/Retail Card - RxImpact (Group A / B / C / D)	$ a /$ a /$ a /$ a	$ a /$ a /$ a /$ a	$ a /$ a /$ a /$ a
Network name			

Additional riders: Please refer to your proposal for rider availability with plan selected.

	Plan [1-3]	**Plan [1-3]**	**Plan [1-3]**
Deductible Carryover Credit	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Supplemental Accident	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Other:	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Special State Options: • Optional Behavioral Health Benefit	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Health Questionnaire for groups enrolling [2-99] employees: (check all that apply)

1. [Has any employee been unable to work [0-10] or more consecutive days in the past [1-12] months due to an illness or injury? ☐ No ☐ Yes]
2. [Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury? ☐ No ☐ Yes]
3. [To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period:
   - [confined at home, in a hospital, or in a treatment facility ☐ No ☐ Yes]
   - [who incurred more than $[1-10,000] of medical expenses in the past [1-24] months ☐ No ☐ Yes]
   - [who has been advised within the last [1-90] days to have surgery or be hospitalized ☐ No ☐ Yes]]
4. [To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past [1-24] months for any of the following:

• AIDS or an AIDS-related complex or other immune system disorder	☐ No ☐ Yes	• Diabetes or any disease or disorder of the kidneys, liver or lungs	☐ No ☐ Yes
• Alcohol or drug abuse or dependence, or psychological disorder	☐ No ☐ Yes	• Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy	☐ No ☐ Yes
• Cancer or cancerous tumor	☐ No ☐ Yes	• Heart or vascular disease or stroke	☐ No ☐ Yes
• Organ transplant (other than corneal)	☐ No ☐ Yes]		

[If you answered yes to questions 1-4 above, please indicate the question number and explanation. Attach additional signed and dated sheets (reorder GN-52334) if necessary.

Question #	Member Status*	Age	Medical Condition/ Diagnosis	Date(s) of Treatment	Medication Name/ Dosage	Past/Current/Future Treatment
						]

* Member Status: E=Employee D=Dependent C=COBRA/State Continuation R=Retiree Class

[Has your company, at any time during the past [1-24] months, had medical coverage terminated or a renewal of medical coverage refused? ☐ No ☐ Yes] [If yes, please explain:_____]

[Have any medical benefits now, or within the past [1-24] months, been funded by you in any manner other than health insurance premium payment? ☐ No ☐ Yes] [If yes, please provide details and attach medical claims experience for the applicable time period up to [1-24] months.]]

[a-z]. DENTAL PLANS (all group sizes)

	Plan [1-2]	Plan [1-2]
Plan name (as shown on your proposal)		
Funding type	☐ Employer sponsored ☐ Voluntary	☐ Employer sponsored ☐ Voluntary
Coinsurance	In % / / Out % / /	In % / / Out % / /
Deductible	In $ Out $	In $ Out $
Annual Maximum	$	$
Preventive Services deductible options	☐ Apply deductible ☐ Waive deductible	☐ Apply deductible ☐ Waive deductible
Periodontic/Endondontic options	☐ Basic ☐ Major	☐ Basic ☐ Major
Composite Fillings for Molars	☐ No ☐ Yes	☐ No ☐ Yes
Implant Coverage	☐ No ☐ Yes	☐ No ☐ Yes
Orthodontia options	☐ Child only: Lifetime Ortho Max $_____ ☐ Adult & Child: Lifetime Ortho Max $ _____	☐ Child only: Lifetime Ortho Max $_____ ☐ Adult & Child: Lifetime Ortho Max $ _____
Out of network reimbursement options	☐ Max allowable fee ☐ In-network fee schedule	☐ Max allowable fee ☐ In-network fee schedule
Open Enrollment	☐ No ☐ Yes	

[a-z]. LIFE (all group sizes) - Please refer to your proposal

Basic Employee Life and AD&D (AD&D only applicable to certain plans)

☐ Flat amount—indicate level: $_____ Increment (if applicable) $_____

☐ Salary plan—options are [1x to 6+x] salary, rounded to the next highest $[1-1,000]. Indicate salary level: _____ x salary

☐ Class schedule—no more than [1-2.5] times between the classes and 10 times between the lowest and highest class (complete table below).

Class	Description	Benefit Amount / Salary Factor
I		
II		
III		
IV		

Basic Dependent Life ☐ No ☐ Yes If yes, indicate volume amount ☐ $10,000/$5,000 ☐ $5,000/$2,500

Voluntary Life

Voluntary Employee Life ☐ No ☐ Yes If yes, do you want to select AD&D? ☐ No ☐ Yes

Voluntary Dependent Life (Available only when enrolled in Voluntary Life) ☐ No ☐ Yes

Portability of coverage (Applicable to Voluntary Life only) Groups 2-99: Included

[a-z]. GROUP CRITICAL ILLNESS (all group sizes)

[Plan design] [☐ Benefits provided in conjunction with a HSA plan] [☐ Benefits offered in conjunction with an IRS-qualified pre-tax plan]

[Coverage choices] [[☐ Vascular] [Heart attack _____% of face amount] [Heart transplant _____% of face amount]
[Stroke _____% of face amount] [Coronary artery bypass surgery _____% of face amount]]
[[☐ Cancer] [Invasive cancer or malignant melanoma _____% of face amount]
[Carcinoma in situ _____% of face amount]]
[[☐ Other critical illness 50 or 100% of face amount] [☐ Major organ transplant] [☐ End stage renal failure]
[☐ Loss of vision, speech or hearing] [☐ Coma]
[☐ Severe burns] [☐ Permanent paralyais due to accident]]
[☐ Occupational HIV benefit]

[Optional benefits - Employer selectable] [☐ None] [☐ Benefit Recurrence _____% of face amount]
[☐ Takeover benefits] [☐ Health screening benefit: ☐ $50 ☐ $100 ☐ $150]
[☐ Loss of work: _____ maximum number of months]

[Face amount (employee/member)] [☐ Class I Basic: $_____] [☐ Class I Buy-up/Optional: $_____]
[☐ Class II Basic: $_____] [☐ Class II Buy-up/Optional: $_____]

[Family options] [☐ Spouse Basic: $_____ or _____% of employee/member amount] [☐ Buy-up/Optional: $_____ or _____% of employee/member amount]
[☐ Child(ren) Basic: $_____ or _____% of employee/member amount] [☐ Buy-up/Optional: $_____ or _____% of employee/member amount]

[Maximum benefit amount] [☐ Basic: $_____] [☐ Buy-up/Optional: $_____]

[Waiver of premium] [☐ Included]

[a-z]. VISION PLANS (all group sizes)

Plan name (as shown on your proposal)

[a-z]. SHORT TERM DISABILITY (group sizes [2+]). Attach additional signed and dated sheets (reorder GN-52336) if necessary.

	Class [1-2]	**Class [1-2]**
[Name of Class]		
[Funding type]	[☐ Contributory] [☐ Non-contributory] [☐ Voluntary]	[☐ Contributory] [☐ Non-contributory] [☐ Voluntary]
[Benefit schedule (select one)]	[☐ [0-100]%] [☐ [0-100]%] [☐ [0-100]%] [☐ Other] [☐ Flat amount $_____]	[☐ [0-100]%] [☐ [0-100]%] [☐ [0-100]%] [☐ Other] [☐ Flat amount $_____]
[Weekly benefit maximum]	[$]	[$]
[Duration weeks]	[Weeks:] [☐ 13] [☐ 26] [☐ 52] [☐ Other _____]	[Weeks:] [☐ 13] [☐ 26] [☐ 52] [☐ Other _____]
[Elimination period]	[☐ 1/8] [☐ 8/8] [☐ 15/15] [☐ 30/30] [☐ Other __]	[☐ 1/8] [☐ 8/8] [☐ 15/15] [☐ 30/30] [☐ Other __]
[Pre-existing limitation]	[☐ None] [☐ 3/3/12]	[☐ None] [☐ 3/3/12]
[Actively at work]	[_____hrs per] [☐ week] [☐ month] [☐ Other_____]	[_____hrs per] [☐ week] [☐ month] [☐ Other_____]
[Waiting period: Current employees]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]
[Waiting period: Rehired employees]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]
[Rate guarantee]	[Year:] [☐ 2] [☐ Other_____]	[Year:] [☐ 2] [☐ Other_____]

[a-z]. LONG TERM DISABILITY (for group sizes 2+) Attach additional signed and dated sheets (reorder GN-52336) if necessary.

	Class [1-2]	**Class [1-2]**
[Name of Class]		
[Funding type]	[☐ Contributory] [☐ Non-contributory] [☐ Voluntary]	[☐ Contributory] [☐ Non-contributory] [☐ Voluntary]
[Benefit schedule (select one)]	[☐ [0-100]%] [☐ [0-100]%] [☐ [0-100]%] [☐ Other] [☐ Flat amount $_____]	[☐ [0-100]%] [☐ [0-100]%] [☐ [0-100]%] [☐ Other] [☐ Flat amount $_____]
[Monthly benefit minimum]	[☐ $100] [☐ 10]% of monthly salary	[☐ $100] [☐ 10]% of monthly salary
[Monthly benefit maximum]	[$]	[$]
[Duration]	[☐ 2 Year] [☐ 5 Year] [☐ SSNRA] [☐ Other_____]	[☐ 2 Year] [☐ 5 Year] [☐ SSNRA] [☐ Other_____]
[Elimination period]	[Days:] [☐ 30] [☐ 60] [☐ 90] [☐ 120] [☐ Other ___]	[Days:] [☐ 30] [☐ 60] [☐ 90] [☐ 120] [☐ Other ___]
[Definition of disability]	[Years own occupation:] [☐ 2] [☐ 3] [☐ to age 65] [☐ Other_____]	[Years own occupation:] [☐ 2] [☐ 3] [☐ to age 65] [☐ Other_____]
[Pre-existing limitation]	[☐ 3/3/12] [☐ 3/6/12] [☐ 6/6/12] [☐ 6/6/24] [☐ 12/12/24] [☐ Other_____]	[☐ 3/3/12] [☐ 3/6/12] [☐ 6/6/12] [☐ 6/6/24] [☐ 12/12/24] [☐ Other_____]
[Mental health and substance abuse limitation]	[☐ 24 months] [☐ Other_____]	[☐ 24 months] [☐ Other_____]
[Survivor benefits]	[☐ 3 x] [☐ 6 x] lump sum	[☐ 3 x] [☐ 6 x] lump sum
[Waiting period: Current employees]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]
[Waiting period: Rehired employees]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]	[☐ Eligible on date of employment] [☐ Eligible after active employment for _____ days]
[Rate guarantee]	[Year:] [☐ 2] [☐ 3] [☐ Other_____]	[Year:] [☐ 2] [☐ 3] [☐ Other_____]

Additional benefits (for LTD only): Please refer to your proposal for additional benefits availability with plan selected. Attach additional signed and dated sheets (reorder GN-52336) if necessary.

	Class [1-2]	**Class [1-2]**
[Cost of Living Adjustment ([0-100]%)]	[☐ No ☐ Yes] [If yes, select years: ☐ 5 ☐ 10]	[☐ No ☐ Yes] [If yes, select years: ☐ 5 ☐ 10]
[Activities of Daily Living]	[☐ No ☐ Yes] [If yes, select %: [☐ [0-100]] [☐ [0-100]] [☐ [0-100]] [☐ [0-100]]]	[☐ No ☐ Yes] [If yes, select %: [☐ [0-100]] [☐ [0-100]] [☐ [0-100]] [☐ [0-100]]]
[Extended Earnings]	[☐ No ☐ Yes]	[☐ No ☐ Yes]
[Medical Premium Supplemental]	[☐ No ☐ Yes]	[☐ No ☐ Yes]

[a-z]. WORKPLACE VOLUNTARY (all group sizes)

[DISABILITY]	[☐ No ☐ Yes]	[**Plan design**] [☐ Benefits are provided in conjunction with a HSA plan] [☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]
[Benefit period (select all that apply)]		[☐ 3 Months] [☐ 6 Months] [☐ 1 Year] [☐ 2 Years] [☐ 3 Years]
[Elimination period (select all that apply)]		[☐ 0/7] [☐ 7/7] [☐ 0/14] [☐ 14/14] [☐ 30/30] [☐ 60/60] [☐ 90/90] [☐ 180/180] [☐ 365/365]
[Optional benefits - Employer selectable]		[☐ **Loss of Work**] [☐ **24 Hour Coverage Rider**] [☐ **Takeover benefit**] [☐ Mental, Nervous, Alcohol and Drug Abuse Rider] [☐ Portability] [☐ Sickness Elimination Period Waiver (Available only if 7 or 14 day Elimination Period is selected for Sickness)]
[Optional benefits - Employee selectable]		[☐ **COBRA benefit**] [☐ **Physical Therapy benefit**] [☐ **ICU/CCU**]
[ACCIDENT INSURANCE]	[☐ No ☐ Yes]	[**Base plan**] [☐ Level 1] [☐ Level 2] [☐ Level 3] [☐ Level 4]
[Optional Benefits]		[☐ Hospital Intensive Care Unit benefit] [☐ $150] [☐ $300] [☐ $450] [☐ $600] [☐ Fracture and Dislocation benefit] [☐ $750] [☐ $1,500] [☐ Accident Total Disability benefit (Elimination period)] [☐ 1 Day] [☐ 7 Days] [☐ 14 Days] [☐ 30 Days] [☐ On-the-Job Coverage benefit]
[CRITICAL ILLNESS]	[☐ No ☐ Yes]	[**Plan design**] [☐ Benefits are provided in conjunction with a HSA plan] [☐ Benefits will be offered in conjunction with an IRS-qualified pre-tax plan]
[Coverage choices]		[☐ Vascular] [☐ Cancer] [☐ Other critical illnesses %]
[Optional benefits - Employer selectable]		[☐ **Benefit Recurrence**] **[☐ Loss of Work] [☐ Takeover benefit]**
[Optional benefits - Employee selectable]		[☐ **Health Screening benefit $_____**] **[☐ Automatic Benefit Increase]**
[CRITICAL LIFE]	[☐ No ☐ Yes]	[**Plan design**] [☐ 10 Year] [☐ 20 Year]
[Optional benefits - Employer selectable]		[☐ Waiver of Premium] [☐ Loss of Work] [☐ Takeover benefit] [☐ Additional Benefit Increase] [☐ Accelerated Living benefit - Critical illness ____%] [☐ Accidental Death and Loss of Sight Dismemberment]

[SUPPLEMENTAL HEALTH]	[☐ No☐ Yes]	[**Base plan**] [☐ Plan A]	[☐ Plan B]	[☐ Plan C]	[☐ Plan D]
[Hospital Indemnity] [Hospital First Occurence]		[$[50-6,000]/day] [$[250-4,000]/ day [(days [1-7]),] [$[250-4,000]/day [(days [1-7])]	[$[50-6,000]/day] [$[250-4,000]/ day [(days [1-7]),] [$[250-4,000]/day [(days [1-7])]	[$[50-6,000]/day] [$[250-4,000]/ day [(days [1-7]),] [$[250-4,000]/day [(days [1-7])]	[$[50-6,000]/day] [$[250-4,000]/ day [(days [1-7]),] [$[250-4,000]/day [(days [1-7])]
[Optional benefits - Employer selectable]					
[☐ Emergency Room]		[$[25-6,000]/day (ER),] [$[25-6,000]/ day (urgent care)]	[$[25-6,000]/day (ER),] [$[25-6,000]/ day (urgent care)]	[$[25-6,000]/day (ER),] [$[25-6,000]/ day (urgent care)]	[$[25-6,000]/day (ER),] [$[25-6,000]/ day (urgent care)]
[☐ ICU/CCU/Burn Unit benefit]		[$[50-12,000]/day]	[$[50-12,000]/day]	[$[50-12,000]/day]	[$[50-12,000]/day]
[☐ Surgical Schedule]		[$[500-8,000]]	[$[500-8,000]]	[$[500-8,000]]	[$[500-8,000]]
[☐ Diagnostic, Laboratory and X-ray]		[$[25-200]/test (hospital),] [$[25-200]/test (doctor's office or clinic)]	[$[25-200]/test (hospital),] [$[25-200]/test (doctor's office or clinic)]	[$[25-200]/test (hospital),] [$[25-200]/test (doctor's office or clinic)]	[$[25-200]/test (hospital),] [$[25-200]/test (doctor's office or clinic)]
[☐ Outpatient Office Visit]		[$[25-400]]	[$[25-400]]	[$[25-400]]	[$[25-400]]
[☐ Wellness]		[$[35-600]]	[$[35-600]]	[$[35-600]]	[$[35-600]]

[If multiple plans are selected and plan availability is limited by class, please list what class of employees are eligible for each plan.]

[1-9]. THE FOLLOWING APPLIES TO ALL COMPANIES AND PLANS EXCEPT WORKPLACE VOLUNTARY

The companies listed on this Employer Group Application, severally or collectively as the context may require, are referred to in this application as we, us and our.

You, the participating employer, policyholder, contractholder, or Certificate sponsor, intend to establish, sponsor, and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

Small employer means a person, firm, corporation, partnership or association actively engaged in business, which employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, unless otherwise provided under the state law. Affiliated or subsidiary companies that are eligible to file a combined tax return are considered one employer.

You agree to make available your records which we determine are relevant to this application and group coverage for inspection by the Trustee, Administrator, us or our representative during your normal business hours.

As claims administrator with authority to make claim determinations as described in Section 503 of ERISA, we make final decisions under the Policy or Certificate with respect to determining eligibility for coverage and paying claims for benefits, including deciding appeals of denied claims. As claims administrator, we shall have full and exclusive discretionary authority to: (1) interpret Policy or Certificate provisions; (2) make decisions regarding eligibility for coverage and benefits; and (3) resolve factual questions relating to coverage and benefits.

You understand and agree that failure to remit and pay premium when due will be considered a default in premium payment, and that coverage will be terminated by us, following a grace period of 31 days from the date of non-payment of premium. We may terminate your coverage according to the termination section of the Policy or Certificate. Except for non-payment of premium or when a group or individual is not or has not been eligible for coverage, you will be provided with a 30 day advance written notice, unless a greater period is expressly specified in the Policy. If coverage is terminated by us for non-payment of premium, you will still owe and we will collect all due premium including premium for the grace period.

You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law, after your insurance has been in effect under the Policy for six consecutive months. Changes to premium rates for short term disability plans may differ if you have agreed to participate in a Rate Guarantee program. You will receive advance written notice.

For you to remain eligible for the Policy or Certificate, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility, underwriting and participation requirements will terminate your coverage under the Policy or Certificate. Other termination provisions are stated in the Policy or Certificate.

Based upon our standard underwriting practice, we may require an employee or dependent to submit Evidence of Health Status. We have the right to use the information provided by you and any applicant (employee or dependent) to determine whether coverage will be provided, to determine eligibility and to establish appropriate premiums. Any health related information that has been provided will not be used to decline medical coverage unless permitted by law.

[1-9]. AGREEMENT AND SIGNATURE - Review your policy/certificate carefully

You the employer, understand, agree and represent: You have read this document and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records. You have received and reviewed a proposal and the applicable regulatory information required by your state. Neither you nor the agent/broker/producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company. The first month's estimated premium (which may include a monthly administrative fee), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application before action is taken on this application. Unless we are informed differently, we will perform a one-time electronic check conversion of the first month's premium payment from the account and for the amount designated on the binder check. You will collect any employee contribution toward premium. Our acceptance of premium does not guarantee coverage. You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met. Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage. Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage. If choosing the HDHP Indexing Plan, deductible and out of pocket amounts are established by IRS guidelines. Adjustments to these amounts by the IRS will be made to the policy, without notice, upon renewal of the group. This document will form part of any contract or coverage issued. Coverage is not in effect unless and until you receive written notification from us. If this application is declined, we will return the premium deposit submitted with this application. The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

DO NOT CANCEL ANY CURRENT GROUP COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE FROM US THAT WE HAVE ISSUED COVERAGE.

Dated on: _____ (month, date, year) at _____ (city and state)

By: _____ _____ _____

(Employer printed name) (Employer signature) (Title)

[For Workplace Voluntary Benefits - only necessary for non-employer groups.

By: _____ _____ _____

(Plan sponsor printed name) (Plan sponsor signature) (Title)]

[1-9]. AGENT/PRODUCER INFORMATION

1. Agency of Record (for commissions and correspondence)	2. Agent/Agency of Record (for split commissions)
Name (print or type)	Name (print or type)
Tax ID/Social Security Number/Humana Agent Number	Tax ID/Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent (Producer)	**2. Writing Agent (Producer)**
Name (print or type)	Name (print or type)
Social Security Number/Humana Agent Number	Social Security Number/Humana Agent Number
Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)	Commission split ☐ No ☐ Yes If yes, percentage: (total should equal 100%)

General Agency (Complete only if agency involved in sale)

General agency information pertains to: ☐ Agency of Record ☐ Writing Agent			
Name (print or type)	Tax ID/Humana Agent Number		
Address	City	State	ZIP code

As the Writing Agent/Producer, I acknowledge that I am responsible to meet with the employer submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent's Signature:_____ Date:_____

Employer Application

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Guidance when you need it most

COBRA/STATE CONTINUATION ADDITIONAL INFORMATION

Name of applicant	Qualifying event (e.g. termination of employment, divorce, etc.)	Qualifying event date	COBRA/State Continuation	
			Start date	End date

Signature: _____ Date: _____

[[Medical] plans [insured] [or] [administered] by [Humana Insurance Company].] [[Dental] plans [insured] [or] [administered] by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Dental HMO] plans offered by [American Dental Providers of Arkansas, Inc.]] [[Vision] plans [insured] [or] [administered] by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [Workplace Voluntary] plans insured by [Kanawha Insurance Company].]

Employer Application

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UNDERWRITING REQUIREMENTS

Medical groups less than 100 employees

You, the participating employer, policyholder, contractholder, or group plan sponsor, may not establish, sponsor, and endorse a medical plan from a carrier other than Humana. Medical coverage is available to employers with [[one] [two] or more] enrolled employees. If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists. If less than [10-99] employees are enrolled, you must submit evidence of health status for all employees and dependents. Humana will not use the evidence of health status to decline medical coverage. Minimum employer contribution toward employee premium is [0-100]%. Retiree coverage is available to employers with [26 or more] enrolled employees. Minimum age for retiree coverage is [0-65] for employers with [26 to 50] enrolled employees. There are no excluded class options for small group medical coverage. If you do not maintain eligibility, underwriting, and participation requirements, Humana will terminate your coverage.

Participation

Non-contributory plans	[0-100]%
Contributory plans	[0-100]%

For IL, IN, KY, LA, MI, OH, TN, SC, MS and VA: For groups of [2-4] eligible employees, Humana requires [0-100]% participation with a minimum enrollment of two. For groups of [5+] eligible employees, Humana requires [0-100]% participation, but will allow [0-100]% participation if the difference is due to valid waivers.

Medical groups more than 100 employees

Refer to your proposal for complete underwriting requirements. Underwriting approval is required to offer more than one medical carrier to your employees. If you do not maintain eligibility, underwriting, and participation requirements, Humana will terminate your coverage.

Dental

Underwriting approval is required to offer more than one dental carrier to your employees. Dental coverage is available to employers with [two or more] enrolled employees. If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists. Minimum employer contribution toward employee premium is [0-100]%. This minimum does not apply to Voluntary coverage. Retiree coverage is available to employers with [26 or more] enrolled employees. Minimum age for retiree coverage is [0-65] for employers with [26 to 50] enrolled employees and must be at least [0-50] for [51+] enrolled employees. Excluded class options: hourly, salary, union, non-union, management, non-management. If you do not maintain eligibility, underwriting, and participation requirements, Humana will terminate your coverage.

Participation requirements

Eligible employees	Participation
[1-99+] (Employer Pays 100% of Premium)	[0-100]%
[1-99+] (Employees Contribute to Premium)	[0-100]%
[1-~~99~~+] Eligible Employees with Spousal Waiver	[0-100]%

Voluntary participation requirements:

Eligible employees	Participation
[1-99+] employees	[1-Two] enrolled employees or [0-100]%, whichever is greater.

Life

Basic Life coverage is available to employers with [two or more] enrolled employees. Voluntary life coverage is available to employers with [five or more] enrolled employees. If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists. Minimum employer contribution toward employee premium is [0-100]%. This minimum does not apply to voluntary coverage. Retirees are not eligible for life coverage. Excluded class options: hourly, salary, union, non-union, management, non-management.If you do not maintain eligibility, underwriting, and participation requirements, Humana will terminate your coverage. Single medical carrier: You must have [0-100]% participation of all eligible employees for this coverage, regardless of whether they have medical coverage through their spouse for non-contributory plans. For contributory plans, [0-100]% participation required; minimum employer contribution [0-100]%. Multiple medical carrier: If you offer more than one medical carrier, you must enroll [0-100]% of those employees who take our coverage regardless of the percentage of contribution paid by you. [0-Five] employees or [0-100]%, whichever is greater.

Participation requirements

Non-contributory plans	[1-100]%
Contributory plans	[0-100]%

Vision

Underwriting approval is required to offer more than one vision carrier to your employees. Vision coverage is available to employers with [two or more] enrolled employees. If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists. Minimum employer contribution toward employee premium is [0-100]%. Less than [0-100]% requires the selection of a Voluntary Vision product. Retiree coverage is available to employers with [26 or more] enrolled employees. Minimum age for retiree coverage is age [0-65] for employers with [26 to 50] enrolled employees and must be at least age [0-50] for [51+] enrolled employees. Excluded class options: hourly, salary, union, non-union, management, non-management. If you do not maintain eligibility, underwriting and participation requirements, Humana will terminate your coverage. Dual choicing Vision products is prohibited.

Participation requirements:

[1-10] or more enrolled employees
Group sizes of [2-9] considered if sold with a medical or dental plan with a minimum of [0-100]% participation and no fewer than [1-99+] enrolled employees.

Vision Multiple Choice options

Multiple choice arrangements are not offered for groups with [2-99] lives. For 100+ groups dual-choice arrangements are subject to underwriting review and prior approval.

[[Medical] plans [insured] [or] [administered] by [Humana Insurance Company].] [[Life] plans [insured] [or] [administered] by [Humana Insurance Company] [or] [Kanawha Insurance Company].] [[Dental] plans [insured] [or] [administered] by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Dental HMO] plans offered by [American Dental Providers of Arkansas, Inc.]] [[Vision] plans [insured] [or] [administered] by [Humana Insurance Company] [or] [CompBenefits Insurance Company].]

Employer Application

HUMANA®
Guidance when you need it most

HEALTH QUESTIONNAIRE ADDITIONAL PAGE

Question #	Member Status*	Age	Medical Condition/ Diagnosis	Date(s) of Treatment	Medication Name/ Dosage	Past/Current/Future Treatment

Signature: _____ Date: _____

[[Medical] plans [insured] [or] [administered] by [Humana Insurance Company].]

Employer Application

HUMANA®
Guidance when you need it most

LARGE GROUP COBRA ADDITIONAL INFORMATION

Member Status*	Age	Medical Condition/Diagnosis	Date(s) of Treatment	Medication Name/Dosage	Past/Current/Future Treatment

* Member Status: E=Employee D=Dependent C=COBRA R=Retiree Class

Signature: _____ Date: _____

[[Medical] plans [insured] [or] [administered] by [Humana Insurance Company].]

Employer Application

HUMANA®
Guidance when you need it most

DISABLED DEPENDENTS OVER THE AGE OF 19

Employee name	Dependent name	Statement of disability/diagnosis from attending physician attached? (If no, indicate reason below)		Dependency statement from employee	Current group carrier insuring dependent
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			
		☐ No ☐ Yes			

Signature: _____ Date: _____

[[Medical] plans [insured] [or] [administered] by [Humana Insurance Company].]

Visit us at Humana.com or HumanaSpecialtyBenefits.com

Humana Employee Enrollment Application - [[2-99] Employees] [Specialty Benefits] [Arkansas]

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana". To elect primary care physician or dentist, please complete reorder AR-51340-PP.

[[Medical] [and] [Life] plans [insured] [or] [administered] by [Humana Insurance Company].] [[Dental] plans [insured] [or] [administered] by [HumanaDental Insurance Company] [or] [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Dental HMO] plans offered by [American Dental Providers of Arkansas, Inc.]] [[Vision] plans [insured] [or] [administered] by [Humana Insurance Company] [or] [CompBenefits Insurance Company].] [[Short Term Disability], [Long Term Disability] [and] [Life] plans insured by [Kanawha Insurance Company].]

Please print clearly and fill in each applicable circle. Proposed effective date: _ _ / _ _ / _ _ _ _

Company name	Company city	State

Qualifying Event Instructions Date of Qualifying Event: _ _ / _ _ / _ _ _ _

❍ [New business enrollment] ❍ [Open Enrollment event] ❍ [Dependent birth or adoption] ❍ [Loss of coverage]
❍ [New hire/Newly eligible] ❍ [Rehire/Reinstatement] ❍ [Marital status change] ❍ [Other_____]

Enrollment Information

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	[Disabled? If yes, indicate reason and SSN within the field below.
Employee		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN: N/A - complete in Employee Information section.
Spouse		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Other (specify):		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:]

EMPLOYEE INFORMATION: **[HOURS WORKED PER WEEK:]** [❍ **RETIREE]** **[DATE OF FULL-TIME HIRE:** _ _ / _ _ / _ _ _ _]

SSN #	Street address		APT / Suite / Box
City	State	ZIP code	Phone # ( )
Language: ❍ English ❍ Spanish	E-mail address	Occupation	

Medical

Group #: Benefit #: Class/Div:

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)

Plan name

[1-3]. Prior medical coverage during the past [1-18] months (individual or other group coverage)? ❍ N ❍ Y]

[Prior medical insurance carrier name	Policy #	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _]

[1-3]. Other medical coverage in effect at the same time as this Humana coverage (individual or other group coverage)? ❍ N ❍ Y]

[Other Medical Insurance carrier name	Policy #	**Other coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _ Term date _ _ / _ _ / _ _ _ _]

[1-3]. Medicare coverage:

[Employee coverage: ❍ N ❍ Y]	[Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _]
[Spouse coverage: ❍ N ❍ Y]	[Medicare ID	Effective date _ _ / _ _ / _ _ _ _	Term date _ _ / _ _ / _ _ _ _]]

Health Savings Account

Group #: Benefit #: Class/Div:

If you have medical coverage under another plan, you may not be eligible for an HSA. Please check with your tax advisor for details.

Please refer to Humana's HSA contribution worksheet to calculate your maximum allowed contribution. You can find additional information on HSAs on Humana.com. Select the Quick Link for Spending Account information on the Member page.

[Do you elect the Health Savings Account? ❍ N ❍ Y (If no, complete waiver.)]	Beneficiary for this account will be the employee's estate. You may change beneficiary information on file with the bank that administers the HSA once the account is established.

Dental

Group #: Benefit Class/Div:

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)

Plan name

Last name:	First name:

Dental

[Prior dental coverage during the past [1-12] months (individual or other group coverage)? ❍ N ❍ Y]

[Prior dental insurance carrier name	**Prior coverage type:** ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family	Effective date _ _ / _ _ / _ _ _ _	Policy #
[Prior orthodontia coverage in the past 12 months? ❍ N ❍ Y]		Term date _ _ / _ _ / _ _ _ _	Prior carrier phone # ( )]

Basic Life

Group #: | Benefit #: | Class/Div:

[Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)	
Class (employer will provide you with this information if needed)	Annual salary $]	**[Basic dependent life?** ❍ N ❍ Y If no, complete waiver section.]

Voluntary Life

Group #: | Benefit #: | Class/Div:

[Voluntary employee life coverage? ❍ N ❍ Y]	[Amount (min $1-unlimited) $	Primary beneficiary name (Last, First MI)	Secondary beneficiary name (Last, First MI)]
[Voluntary spouse life coverage? ❍ N ❍ Y]	[Amount (min.$1-unlimited) $]	**[Voluntary child(ren) life coverage?** ❍ N ❍ Y]	[Annual employee salary $]

Vision

Group #: | Benefit #: | Class/Div:

Coverage type: ❍ Employee only ❍ Employee and spouse ❍ Employee and child(ren) ❍ Family ❍ NO COVERAGE (complete waiver)	Plan name

Group Term Disability

Group #: | Benefit #: | Class/Div:

[Short Term Disability ❍ N ❍ Y] [If no, complete waiver section. Buy-up _____%]	[Long Term Disability ❍ N ❍ Y] [If no, complete waiver section. Buy-up _____%]
[Employment status (check one) ❍ Active ❍ Retiree ❍ COBRA]	[Annual salary $]

Group Term Life

Group #: | Benefit #: | Class/Div:

[Employment status (check one) ❍ Active ❍ Retiree ❍ COBRA]	[Annual salary $]

Coverage requested for (check all that apply)		Coverage requested (complete only if plan provides a choice of benefit schedules)	**Cost per pay period $**
[Employee]	❍ [Basic Term Life]		
	❍ [Supplemental Term Life*]		
	❍ [Basic AD&D]		
	❍ [Supplemental AD&D]		
[Spouse]	❍ [Basic Term Life]		
	❍ [Supplemental Term Life*]		
	❍ [Basic AD&D]		
	❍ [Supplemental AD&D]		
[Child(ren)]	❍ [Basic Term Life]		
	❍ [Supplemental Term Life*]		
	❍ [Basic AD&D]		
	❍ [Supplemental AD&D]		

[*Complete Evidence of Insurability form if selecting one of these benefit amounts.]

[Primary beneficiary name (Last, First MI)	Relationship to employee]
[Secondary beneficiary name (Last, First MI)	Relationship to employee]

Last name: First name:

Evidence of Health Status

This information should not be submitted more than [1-60] days prior to the effective date.

Complete this section for employees and dependents enrolling for medical coverage who are members of groups with [2-99] applicants and applicants requesting Life insurance over the guarantee issue amount, and all late enrollees applying for Life coverage.

[1-5]. [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ N ❍ Y]

[1-5]. [Within the past [1-5] years, have you or any eligible dependent to be covered been diagnosed with, counseled, consulted or treated by a doctor for any of the following:

[a-j]	Coronary artery disease, chest pain, or any disease of the arteries or blood vessels; phlebitis; high blood pressure?	❍ N ❍ Y	[a-j]	Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	❍ N ❍ Y
[a-j]	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	❍ N ❍ Y	[a-j]	Stomach, gall bladder, intestinal or colon disorders?	❍ N ❍ Y
[a-j]	Asthma or other disease of lungs or respiratory organs?	❍ N ❍ Y	[a-j]	Rheumatoid arthritis or back disorders?	❍ N ❍ Y
[a-j]	Kidney stones; disease of kidney, bladder, male or female organs; or infertility?	❍ N ❍ Y	[a-j]	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
[a-j]	Cancer, and/or cancerous tumor? (state type & part of body in details section below)	❍ N ❍ Y	[a-j]	Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	❍ N ❍ Y]

[1-5]. [Have you or any dependent been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ Y]
[1-5]. [During the past [1-5] years, have you or any dependent had hospitalization or surgery scheduled or completed, had any injury, illness, medical attention or medical advice or treatment for any reason not already mentioned?	❍ N ❍ Y]
[1-5]. [Are you or any dependent to be covered pregnant? If yes, please indicate anticipated delivery date below. [Anticipated delivery date:_____]	❍ N ❍ Y]

[If you answered "yes" to any of the questions above, please provide details below and specify the question #. Attach additional signed and dated sheets (reorder GN-51340-MH) if necessary.

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _]

Medical Health History

This information should not be submitted more than [1-60] days prior to the effective date.

[1-4].[Are you or any dependents to be covered currently pregnant? If yes, please indicate anticipated delivery date below. [Anticipated delivery date:]	❍ N ❍ Y]
[1-4].[Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ N ❍ Y]
[1-4].[During the last [1-24] months, have you or any dependents to be covered been diagnosed with, or treated for, any illness or injury or had surgery or hospitalization recommended?	❍ N ❍ Y]
[1-4].[Within the past [1-12] months, have you or any dependents to be covered incurred medical expenses in excess of $[1-10,000]?	❍ N ❍ Y]

[If you answered "yes" to any of the questions above, please provide details below and specify the question number. Attach additional signed and dated sheets (reorder GN-51340-MH) if necessary.

Question #	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _]

Last name: First name:

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

[I hereby waive coverage for (check all that apply):	[I decline to apply for group coverage because of:
[Medical for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)]	❍ [Spousal coverage]
[Dental for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)]	❍ [Medicare supplement]
[Basic Life for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)]	❍ [Individual coverage]
[Vision for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)]	❍ [Coverage under another carrier's plan provided by my employer]
[Group Term Disability for: ❍ Myself]	❍ [Other:]]
[Group Term Life for: ❍ Myself]	
[Health Savings Account for: ❍ Myself]]	

Agreement

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-31] days after the qualifying event.
- If I or my dependents becomes eligible for premium subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-60] days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-60] days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to a HDHP.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [0-31] days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. [If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer for the purposes of depositing any contributions.]
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete this application.
- The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/ certificate of insurance issued.

Last name: First name:

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)

[Arkansas] Last name: First name:

Humana Evidence of Health Status - Employee Enrollment Application

Visit us at Humana.com or HumanaSpecialtyBenefits.com

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana". To elect primary care physician or dentist, please complete reorder AR-51340-PP.

[[Medical] [and] [Life] plans [insured] [or] [administered] by [Humana Insurance Company].] [[Short Term Disability], [Long Term Disability] and [Life] plans [insured] [or] [administered] by [Kanawha Insurance Company].]

Please print clearly and fill in each applicable circle.

Company name	Company city	State

Enrollment Information

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	Gender	Full-time student?	Date of birth	[Disabled? If yes, indicate reason and SSN within the field below.
Employee		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN: N/A - complete in Employee Information section.
Spouse		/		❍ F ❍ M	N/A	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Child		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:
Other (specify):		/		❍ F ❍ M	❍ N ❍ Y	_ _ / _ _ / _ _ _ _	❍ N ❍ Y Reason: SSN:]

EMPLOYEE INFORMATION: **[HOURS WORKED PER WEEK:]** **[❍ RETIREE]** **[DATE OF FULL-TIME HIRE: _ _ / _ _ / _ _ _ _]**

SSN #	Street address		APT / Suite / Box
City	State	ZIP code	Phone # ( )
Language: ❍ English ❍ Spanish	E-mail address		Occupation

This information should not be submitted more than [1-60] days prior to the effective date.
Complete this section for applicants requesting medical or life insurance over the guarantee issue amount and all late enrollees applying for life coverage.

[1-5]. [Are you or any dependents currently taking any prescribed medication, or do you periodically take medication for a recurrent condition?	❍ N ❍ Y]

[1-5]. [Within the past five years, have you or any eligible dependent to be covered been diagnosed with, counseled, consulted or treated by a doctor for any of the following:

[a-j]	Coronary artery disease, chest pain, or any disease of the arteries or blood vessels; phlebitis; high blood pressure?	❍ N ❍ Y	[a-j]	Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	❍ N ❍ Y
[a-j]	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	❍ N ❍ Y	[a-j]	Stomach, gall bladder, intestinal or colon disorders?	❍ N ❍ Y
[a-j]	Asthma or other disease of lungs or respiratory organs?	❍ N ❍ Y	[a-j]	Rheumatoid arthritis or back disorders?	❍ N ❍ Y
[a-j]	Kidney stones; disease of kidney, bladder, male or female organs; or infertility?	❍ N ❍ Y	[a-j]	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
[a-j]	Cancer, and/or cancerous tumor? (state type & part of body in details section below)	❍ N ❍ Y	[a-j]	Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	❍ N ❍ Y]

[1-5]. [Have you or any dependent been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ Y]
[1-5]. [During the past five years, have you or any dependent had hospitalization or surgery scheduled or completed, had any injury, illness, medical attention or medical advice or treatment for any reason not already mentioned?	❍ N ❍ Y]
[1-5]. [Are you or any dependent to be covered pregnant? If yes, please indicate anticipated delivery date below. Anticipated delivery date:	❍ N ❍ Y]

[If you answered "yes" to any of the questions above, please provide details below and specify the question #. Attach additional signed and dated sheets (reorder GN-51340-MH) if necessary.

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _]

Last name: First name:

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature is evidence of this action.

[I hereby waive coverage for (check all that apply):	[I decline to apply for group coverage because of:
[Medical for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)]	❍ [Spousal coverage]
[Basic Life for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)]	❍ [Medicare supplement]
[Group Term Life for: ❍ Myself]	❍ [Individual coverage]
	❍ [Coverage under another carrier's plan provided by my employer]
	❍ [Other:]]

Agreement

True and complete acknowledgement

I understand, agree and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/certificate of insurance.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-31] days after the qualifying event.
- If I or my dependents becomes eligible for premium subsidies under Medicaid or the Children's Health Insurance Program (CHIP), I may in the future be able to enroll myself or my dependents provided I request enrollment within [1-60] days after the qualifying event. I understand eligibility for enrollment does not apply to a High Deductible Health Plan (HDHP).
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or certificate provisions which may require additional limitations and waiting periods.
- I may be required to furnish, at my own expense, evidence of health status satisfactory to Humana.
- If I am declining coverage for myself or my dependents (including my spouse) because of coverage under Medicaid or CHIP, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-60] days after my coverage under these programs ends. I understand eligibility for enrollment does not apply to a HDHP.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within [1-31] days after my other coverage ends.
- Humana reserves the right to delay medical coverage and/or deny life or dental coverage with any future application for coverage.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. [If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer for the purposes of depositing any contributions.]
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- If I am applying for coverage for my dependents (including my spouse) I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete this application.
- The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.
- Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Authorization

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by Humana to make claims determinations, determine eligibility for coverage, eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by Humana to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as I (we) may further authorize.

Authorization for Release of Medical Records for Life or Disability

If my dependents or I have selected life or disability, I authorize any third party to have information regarding myself. This includes any medical or non-medical information and to share any and all such information with Humana, its reinsurer or its legal representatives, and its affiliates. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, the recipient may redisclose it and the information may not be protected by federal and state privacy requirements.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/ certificate of insurance issued.

Last name: First name:

Signature - please sign below if enrolling or waiving group

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)

Last name:	First name:

Additional Details to Medical Questions

This information should not be submitted more than 60 days prior to the effective date.
Please print clearly.

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Employee signature ____________________ Date _ _ / _ _ / _ _ _ _

Spouse signature (if covered dependent) ____________________ Date _ _ / _ _ / _ _ _ _

Child signature (if covered dependent over the legal age) ____________________ Date_ _ / _ _ / _ _ _ _

Child signature (if covered dependent over the legal age) ____________________ Date_ _ / _ _ / _ _ _ _

Child signature (if covered dependent over the legal age) ____________________ Date_ _ / _ _ / _ _ _ _

[[Medical] plans [insured] [or] [administered] by [Humana Insurance Company].] [[Life] plans [insured] [or] [administered] by [Humana Insurance Company] [or] [Kanawha Insurance Company].]

SERFF Tracking Number:	*HUMA-126866656*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47117*
Company Tracking Number:	*AR-10-005*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*AR App Maint - HIC Med*		
Project Name/Number:	*Apps Update/Clarity-PROOO24058*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/12/2010

Comments:
see attached

Attachment:
Catron-Certificate of Readability - AR-10-005.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/12/2010
Bypass Reason:	Refer to the Form Schedule Tab for application that will be used.		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/12/2010
Bypass Reason:	na		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	11/12/2010

Comments:
see attached

Attachment:
Statement of Variability.Application.pdf

HUMANA INSURANCE COMPANY

CERTIFICATE OF READABILITY

Filing # AR-10-005

I hereby certify that these forms exceed the minimum reading ease score of 40 required by the State of Arkansas.

J. Gregory Catron
Vice President
Humana Insurance Company

HUMANA.
Guidance when you need it most

Statement of Variability for Application Forms

Bracketed Sections

1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, payment information, or agreements.

2. Bracketed sections are identified by green brackets.

   NOTE: Some exceptions will apply due to state requirements or rulings regarding bracketing.

3. Non-bracketed logos, text, or numbers within the section remains constant and will not be subject to changes without being refiled.

4. Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to any statutory or regulatory requirements.

   - For example: We have filed the Dental section of an application but the applicant did not select Dental then that section will not appear.

5. Bracketed variables such as logos, text, or numbers are subject to change as outlined within the various sections of this document.

Bracketed Numbers

1. With the exception of form numbers and matrix numbers, if allowed by the state, all bracketed numbers are variable.

   - Form numbers are located in the lower left-hand corner of the form and are not subject to change without refilling.

   - Reorder numbers (Group forms) and Revision numbers (Individual forms) are located in the lower right-hand corner of the form and are considered variable and included within this statement.

2. Bracketed numbers within a section are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.

3. Bracketed numbers will include the minimum and maximum ranges.

4. If the state determines ranges are not acceptable, only a single number will be shown on the form and that number will not be bracketed.

Bracketed Questions

1. Text within the bracketed question will not change (Refers to language only. See # 3 for formatting and placement changes).

2. Any bracketed variables within that question are subject to change.

3. Bracketed questions vary only to the extent that such questions may be included, omitted or transferred within the form subject to any statutory or regulatory requirements.

Instructions or Help Text

1. Bracketed instructional text varies to the extent that such text may be included, omitted or transferred to another page to meet the needs of applicants completing the application.

2. Humana reserves the right to make minor instructional or help text revisions, even if it is not bracketed, as needed to clarify instructions for completion of the application and amend the language to clarify the intent within the confines of the law.

Product Information

1. Product information may vary to the extent such information may be included, omitted, or transferred to another page subject to any statutory or regulatory requirements

2. Additional fields within an existing product offering section can be added to an application without refiling for the purpose of offering new insurance products or benefits subject to
    - prior approval of certificate or policy forms for the new products or benefits; and,
    - any statutory or regulatory requirements

Legal Entities

1. New product or benefit plan designs or offerings that create a new or modify an existing legal entity will require filing.

2. Legal entities will be bracketed when multiple entities are listed as insuring or administering entities. The applicable entity(s) will be shown based upon the applicant's/groups selection.

3. If there is only one legal entity listed as insuring or administering then it will not be bracketed

Demographic Information

Demographic information will not be bracketed but will fall under administrative changes which can be amended without refiling.

Administrative Changes and Clerical Errors

Humana reserves the right to amend the attached form(s) for any minor administrative changes or to fix clerical errors that may have unintentionally gone unnoticed prior to submitting for approval and to amend the language to clarify the intent within the confines of the law.

Forms are submitted in filing version format and are subject only to minor modification in paper size, stock, ink, border, and adaptation to computer printing. The application may be offered in a printed, on line, or digitized audio recorded format.